BEFORE THE ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

In the Matter of **KEVIN EARLYWINE, P.A.-C** Holder of License No. **2140** For Practice as a Physician Assistant In the State of Arizona.	Case No. PA-04-0048A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR A DECREE OF CENSURE**

The Arizona Regulatory Board of Physician Assistants ("Board") considered this matter at its public meeting on May 17, 2006. Kevin Earlywine, P.A.-C ("Respondent") appeared before the Board with legal counsel Andrew Plattner for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-2551. The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of physician assistants in the State of Arizona.

2. Respondent is the holder of license number 2140 for the performance of healthcare tasks in the State of Arizona.

3. The Board initiated case number PA-04-0048A after receiving an anonymous complaint regarding Respondent's care and treatment of a fifty-one year-old female patient ("CK"). On October 21, 2004 Respondent was asked to provide to the Board by November 4, 2004 a complete copy of his medical records for CK. On November 11, 2004 Respondent submitted an incomplete record dated from May 3, 2004 to August 12, 2004. The record submitted did not include an October 26, 2004 office visit, a pain management contract, or copies of Schedule III prescriptions written by him. The complete record was not submitted until December 15, 2004.

4. Respondent began seeing CK at Lakeside Primary Care on May 3, 2004. CK's diagnosis was severe degenerative disk disease, degenerative joint disease, osteoarthritis, chronic pain management for the previous several years on Darvocet, and occasional use of Soma and Lortab that allowed her to function. CK had a history of coronary artery disease, hyponatremia, migraine headaches and seizure disorder, for which she was taking Tegretol. Respondent had previously cared for CK while working as a physician assistant for another physician ("Dr. C") and was familiar with her history and previous X-ray and MRI results. Respondent was also aware CK had failed using multiple medications, including NSAIDs and epidurals, and a neurosurgeon had suggested medical management only.

5. Respondent continued CK's regimen of medications and asked her previous primary care physician and cardiologist for CK's records. Respondent maintained he never received these records and believes he did not receive them because of animosity other physicians felt toward him. Respondent saw CK eight more times between May 3, 2004 and April 8, 2005 for the same diagnoses. There is also a note from an October 7, 2005 visit in the records. On July 15, 2004 CK reported increased pain and that Darvocet was not working. Respondent then prescribed Lortab. Laboratory tests reported on July 16, 2004 note sodium at 130. Respondent noted he made a second request to obtain CK's records, however there are no copies of the request in the record.

6. On August 12, 2004 Respondent saw CK for follow-up and she reported better pain control with Lortab 10/500 as approved by Respondent's supervising physician, Steven Cervi-Skinner, M.D. Respondent reviewed the low sodium and noted it was called to CK on July 16, 2004 and sent to her cardiologist. Respondent read an X-ray of CK's knee as severe degenerative change, but the radiologist reported a mild degenerative disease of the knees. Respondent ordered repeat sodium and chloride levels and prescribed Nexium and Phenergan,

but there is no reason stated in Respondent's records for these prescriptions. For instance, Respondent did not document any complaints of nausea or ulcer type symptoms or diagnosis.

7. CK was hospitalized at Navapache Regional Medical Center ("NRMC") from August 28, 2004 to September 5, 2004 for cough, chills and "hurting all over." CK was diagnosed with bilateral pneumonia and hyponatremia with sodium at 120. CK had a physician primary caretaker in the hospital, but was also seen by a cardiologist, an internal medicine physician, and a neurologist. All caretakers decided to stop the Tegretol because they thought it was the cause of CK's low sodium levels and they prescribed Clonazepam in its place. CK was also treated with salt tablets, antibiotics and other supportive pulmonary and electrolyte care. The emergency nursing records note CK's primary care provider is "Lakeside Primary Earlywine PA," but there is no indication in the hospital records Respondent was notified of CK's admission. CK's discharge instructions told her to follow-up with the physician who was her primary caretaker in the hospital and on September 14, 2004 she did. CK voiced her concern over stopping the Tegretol because of her seizure disorder, but the physician felt stopping the Tegretol was a good approach to see if her hyponatremia would correct.

8. CK was brought to NRMC again on October 2, 2004 with confusion, "SOB," complaining of a headache and a concern she may have fallen the night before. CK remained hospitalized until October 6, 2004. The radio report to NRMC was "disoriented, naked, fell last night confused." The same physician who treated CK during the September admission assumed her care. An MRI showed multiple areas of hyperintense signal changes involving deep white matter of the cerebral hemispheres and raised the physician's concern about a possible demyelinating process, such as MS. CK again had bilateral interstitial infiltrates and was noted to have hyponatremia with sodium at 129. CK was seen by the same internal medicine physician and neurologist. The internal medicine physician felt CK's mental status changes could be due to many things, but ultimately felt they were related to an unintentional overuse of multiple narcotics.

The record indicates CK had continued the Tegretol against medical advice and she reported it was for restless leg syndrome, not seizures. The neurologist wanted to look into CK's past medical records and previous prescribing history due to concerns about overmedicating and urged CK to cut back on her Lortab and Soma. An EEG was mildly abnormal secondary to generalized slowing thought to be secondary to medication as opposed to ischemic insult. CK was treated with electrolyte support, Clonazepam, antibiotics and pulmonary support. CK's Lortab and Soma were held and she was placed on Ibuprofen for pain. On discharge from NRMC CK signed orders that she was to get her medication only from the primary physician who had treated her in the hospital and to follow-up with him. CK did not follow-up.

9. At an October 26, 2004 office visit with Respondent, CK sought his opinion regarding the recommendations of NRMC physicians. CK told Respondent she was not using any pain medication, but pharmacy surveys indicate on October 10, 2004 and October 25, 2004 CK filled Lortab prescriptions for #60 tablets each. Respondent instructed CK to continue her care with the physician who treated her in the hospital, noted a pending referral to a pulmonologist and asked her to make sure the treating physician made the referral. Respondent informed CK he would be happy to continue her care once he received all the appropriate records and he noted his concern that CK was on Clonazepam with the depression she was feeling and that she was not receiving adequate pain control. On this same date, CK signed a pain contract with Respondent.

10. CK returned to Respondent on December 2, 2004 and asked him to resume her care because she had no faith in the other physicians. Respondent agreed and tried to get her records from the physician who treated her in the hospital, and ordered lab work to check her sodium. Respondent stopped CK's Parafon Forte because it was not helping her and placed her back on Soma. CK was off Tegretol. During an interview with Board Staff, Respondent admitted CK had not had any seizures while off Tegretol. For a March 23, 2005 office visit there are two

handwritten notes that are slightly different, but only one dictated/typed note. In an interview with Board Staff, Respondent stated there were two notes because CK had been in a car accident and asked him to write a note to the insurance company.

11. CK saw Respondent on October 7, 2005 for follow-up of back pain. CK reported her pain was more diffuse and associated with an altered sleep pattern. CK was still on Soma and Respondent added Tylenol #3. CK's diagnosis list is more extensive in Respondent's new electronic medical program and included Lumbar DJD, Osteoarthritis, Spinal stenosis, Fibromyalgia, radiculitis, psychogenic pain, etc. Respondent documented he discussed the potential for addiction and habituation with narcotics. Respondent referred CK to cardiology, psychology, pain management and weight management.

12. Between May 5, 2004 and April 8, 2005 Respondent prescribed Soma, Darvocet, Lortab or Tylenol #4 for treatment. Respondent did not exceed the fourteen prescribing restriction for the Lortab or Tylenol #4 during this time and did not exceed the restriction on prescribing five times in a six month period of Schedule IV and V controlled substances. However, from May 2005 to November 2005 Respondent wrote the following prescriptions for Schedule IV controlled substances: seven prescriptions for Soma, eight prescriptions for Tylenol #4, and seven prescriptions for Clonazepam.

13. Respondent testified he practices at a clinic in the Pinetop/Lakeside area. The Board asked if CK was still under the care of a cardiologist, a pain specialist, and a neurologist. Respondent testified CK was still under the care of a cardiologist and had been referred several times to a pain specialist. The Board confirmed Respondent was CK's primary care provider and asked if Dr. Cervi-Skinner had ever seen CK. Respondent testified he had not. The Board asked if Respondent found it unusual that CK was being seen by him, followed by medical specialists, but not seen by his supervising physician. Respondent agreed it was unusual.

14. The Board noted Respondent's supervising relationship with a "Dr. C" was severed on April 10th 2004 and his relationship with Dr. Cervi-Skinner was not approved until April 21st. Respondent testified he did not see patients from when his relationship with Dr. C was severed until the end of April when he opened his office. However, a pharmacy survey lists Respondent as the prescriber for an April 19, 2004 prescription written to CK for Soma. The Board confirmed Respondent graduated in 1998 and his background was in a cardiac practice in metropolitan Phoenix until he moved to Pinetop/Lakeside to purchase Dr. C's practice with Dr. C staying on as his supervising physician. Respondent testified he worked with Dr. C for a couple of years, but then Dr. C refused to sell him the practice and he left. Respondent testified he then set up his supervisory relationship with Dr. Cervi-Skinner and opened his clinic for family practice.

15. The Board asked Respondent about the allegation against him that he did not affix "P.A." after his name when signing charts. Respondent testified when he first opened his practice he was doing dictation and it would be put at the end of his dictation, but when he went to electronic medical records at the end of last summer there was an oversight and it was not included for a period of more than one month. The Board noted its investigators had contacted Respondent's office representing themselves as potential patients and asked what physicians were available to see patients. During those contacts Respondent's staff informed the investigators "Doctor Earlywine" was available to see patients. Respondent testified he was not aware of this, it is not a general practice, and he is not introduced as such. The Board asked if Respondent had a sign in front of his office indicating he was a physician assistant. Respondent testified there are two signs – one large sign and writing on the office window – that say "Lakeside Primary Care, Kevin Earlywine, P.A.-C."

16. The Board asked how often Respondent and Dr. Cervi-Skinner have supervisory visits. Respondent testified they meet every week either at Dr. Cervi-Skinner's home or the hospital. The Board asked what type of practice Dr. Cervi-Skinner was engaged in. Respondent

testified Dr. Cervi-Skinner is an internist, an in-patient hospitalist, in the Phoenix metropolitan area. The Board confirmed Dr. Cervi-Skinner did not have an out-patient practice and did not come to Respondent's clinic to see patients. The Board asked if Respondent had hospital privileges in the Pinetop/Lakeside area. Respondent testified he did not. The Board asked how then he hospitalized patients. Respondent testified he contacts local internists or family practice physicians in the area. The Board asked if any of these physicians would be willing to serve as an agent of Dr. Cervi-Skinner and supervise Respondent. Respondent testified there had been a couple of offers, but it has not happened yet.

17. The Board noted it appeared Respondent was functioning as a physician without any real oversight other than by facsimile, phone, or meeting to discuss patients that Dr. Cervi-Skinner did not have first-hand knowledge of. The Board asked if Respondent had ever not met weekly on a face-to-face basis with Dr. Cervi-Skinner. Respondent testified there may have been a couple of occasions when the weekly meetings were missed.

18. The Board asked if Respondent was aware of narcotic pain management prescribing guidelines, pain contracts, etc. Respondent testified he was. The Board asked Respondent to explain his five month delay in having CK sign a pain contract. Respondent noted if the Board had a copy of the pain contract CK signed one year later it was because they renew them every year and the second year one was sent and that would explain the date on it. The Board asked if when CK first presented to Respondent and he decided on a course of treatment CK signed a contract. Respondent testified she did and assumed the Board had a copy because it would be part of CK's chart. Board Staff confirmed it only had one pain contract that was received after a second request for the complete medical file and, although Respondent began seeing CK in May 2004, the contract was not dated until October 2004.

19. The Board confirmed Dr. Cervi-Skinner lived and worked in the Phoenix metropolitan area. Respondent testified it was never his intention to not have Dr. Cervi-Skinner

seeing patients on a once per month basis or a once every other week basis. Respondent testified they were working on a contract to perform hospital work in the White Mountains and hoped to have it done so he would have Dr. Cervi-Skinner and a couple of other physicians in the office, but it is not going to happen until fall of 2006. The Board asked when Respondent last met with Dr. Cervi-Skinner. Respondent testified he met with Dr. Cervi-Skinner the previous week at the hospital and the week before that at Dr. Cervi-Skinner's home. The Board asked how many medical records he typically brought with him. Respondent testified on average he brings forty to sixty and Dr. Cervi-Skinner reviews them all. The Board asked if Dr. Cervi-Skinner had ever seen Respondent's office and what type of facility he had. Respondent testified Dr. Cervi-Skinner has seen it in pictures. The Board asked if Dr. Cervi-Skinner knew what kind of staff Respondent had, what kind of set-up, what capabilities Respondent had, and what Respondent's filing system was like. Respondent testified he did not.

20. The Board asked if Respondent saw patients with gynecologic problems. Respondent testified he had in the past, but most are referred to a gynecologist. The Board confirmed Dr. Cervi-Skinner was an internist/hospitalist. The Board asked if Respondent saw babies or small children in his practice. Respondent testified he generally did not and referred most of them to pediatricians, but did see them occasionally if the parents requested it. The Board asked how many children Respondent saw at the clinic in the last month. Respondent testified he saw ten. The Board asked how many children Dr. Cervi-Skinner had seen in an office setting in the last year. Respondent testified Dr. Cervi-Skinner had not seen any children.

21. The Board asked if Respondent was writing the allowed fourteen day prescriptions and then seeing the patient at the end of the fourteen days and giving them another prescription. Respondent testified he sees the patients once per month and if they are getting continuing narcotics Dr. Cervi-Skinner will usually sign the next prescription. The Board asked if it was Respondent's position that he had not made errors in prescribing narcotics to CK. Respondent

testified he had not intentionally made errors. The Board referred to the pharmacy survey and noted it reflected prescriptions every fourteen days for CK. The Board asked why Respondent did not have a supervising physician located where he was practicing. Respondent testified his intention was not to be alone in his practice and that was never the way he wanted to practice. Respondent noted he left the milieu where he practiced in a large cardiology group and felt very comfortable with several cardiologists around him. Respondent testified he went to the White Mountains to purchase a practice, but the sellers refused to sell it after taking a lot of his money. Respondent testified his options when the sale fell through were to return to the Valley and work in cardiology again, but his family loves the White Mountains and he wants to raise his children there, so his option was to figure out how to open a practice there. Respondent testified his intention was to have a physician on site and he has had a couple of offers, but things have not worked out. Respondent testified he had a lot of problems because he was black listed by a lot of physicians in the area and it has been a hard environment to work in. Respondent testified his intention was to have a physician on site at all times and this is going to be happening very soon.

22. Respondent noted the complaint in this case was filed anonymously and CK continues to see him on a regular basis. Respondent testified CK was not hospitalized because of the medications he prescribed, but was hospitalized and Tegretol was withheld and she had a subsequent seizure and ended up in the hospital. Respondent testified he sent CK to see the doctor who took care of her in the hospital, but she refused to see him because he withheld her Tegretol and that is why she had the seizure.

23. The standard of care required Respondent to execute a pain contract with CK and conduct urine testing to ensure CK was not abusing the controlled substances he prescribed.

24. Respondent deviated from the standard of care because he did not execute a pain contract with CK until five months after he began prescribing opiates and because he did not conduct urine to ensure CK was not abusing the substances he prescribed.

25. CK was exposed to the potential harm of dependence on and of abuse of the controlled substances Respondent prescribed.

26. Respondent is required to maintain adequate records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. Respondent's records were inadequate because they did not contain supporting and corroborating previous medical records for CK and because there is no corroborating evidence in the records that there was a severe or moderately severe process causing her pain. The only X-ray report in the records is of CK's knees and shows only mild degenerative changes.

CONCLUSIONS OF LAW

1. The Board on the Regulation of Physician Assistants possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances above constitute unprofessional conduct pursuant to A.R.S. § 32-2501(21)(a) ("[v]iolation of any federal or state law or rule that applies to the performance of health care tasks as a physician assistant . . .); specifically, A.R.S. § 32-2532(C) ("[u]nless certified for fourteen day prescription privileges pursuant to section 32-2504, subsection A, a physician assistant shall not prescribe a schedule II or III controlled substance for a period exceeding seventy-two hours. For each schedule IV or schedule V controlled substance, a physician assistant may not prescribe the controlled substance more than five times in a six month period for each patient"); and A.R.S. § 32-2534(A) ("[a] physician assistant shall not

perform health care tasks until the supervising physician receives approval of the notification of supervision from the board"); A.R.S. § 32-2501(21)(m) ("[f]ailing to use and affix the initials "P.A." or P.A.-C." after the physician assistant's name or signature on charts, prescriptions or professional correspondence"); A.R.S. § 32-2501(21)(p) ("[f]ailing or refusing to maintain adequate records on a patient"); A.R.S. § 32-2501(21)(s) ("[p]rescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted purposes"); and A.R.S. § 32-2501(21)(z) ("[f]ailing to furnish legally requested information to the board or its investigator in a timely manner").

ORDER

Based upon the foregoing, IT IS HEREBY ORDERED that:

1. Respondent is issued a Decree of Censure for failing to maintain adequate patient records, failing to use and affix "P.A.-C." to charts, inappropriate prescribing of opiates, failing to provide information to the Board in a timely manner, for not entering a pain contract with a patient for prescribing medications before receiving Board approval of supervising physician and for failing to conduct urine screens on a patient to whom he was prescribing opiates.

RIGHT TO PETITION FOR REHEARING

Respondent is hereby notified that he has the right to petition for a rehearing. The petition for rehearing must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09. The petition must set forth legally sufficient reasons for granting a rehearing. A.A.C. R4-17-403. Service of this Order is effective five (5) days after date of mailing. If a motion for rehearing is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing is required to preserve any rights of appeal to the Superior Court.

DATED this 1st day of September, 2006.

ARIZONA REGULATORY BOARD OF
PHYSICIAN ASSISTANTS

TIMOTHY C. MILLER, J.D.
Executive Director

Original of the foregoing filed this
1st day of September, 2006 with:

Arizona Regulatory Board of
Physician Assistants
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. mail this
1st day of September, 2006, to:

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